County of Los Angeles – Department of Mental Health
Local Mental Health Plan
REQUEST FOR CHANGE OF PROVIDER
CONFIDENTIAL

To request a change in your current provider, please submit this form to the Program Manager's office. Every effort will be made to accommodate your request. You will receive a decision within 10 working days. If you are a Medi-Cal beneficiary seeing a private provider in the community who is not part of a county operated or county contracted program, call the Beneficiary Services Program in the Patients' Rights Office at 800-700-9996 or 213-738-4949. The Mental Health Plan cannot guarantee that your provider will be changed. If you do not receive a decision on your request within 10 working days or you disagree with the decision, you may file a formal grievance.

SECTION 1 CURRENT PROVIDER INFORMATION (Clients please fill out Section 1 & 2 ONLY)

DATE:_____SERVICE LOCATION:_____

PROVIDER NAME:_____

SECTION 2 BENEFICIARY/CLIENT INFORMATION

Client Name:_____Birthdate:_____

Address:_____City:_____State:_____/ZipCode:_____

Phone Number:_____

1. I am requesting a change in:
   - ❑ Service Staff ☐ Medical Staff ☐ Program

2. Please describe the reason(s) for requesting a change. (**This information is optional)**

_____

_____

_____

_____

3. Have you discussed your concerns with your current provider?
   - ❑ Yes (Please describe what you have done to try to resolve the problem)

_____

_____

_____

   - ❑ No

_____

I understand that I will be contacted about this request within 10 working days.

I prefer to be contacted by: Mail ☐ Telephone ☐ Email ☐

Today's Date:_____

Signature of Person making request_____

Parent/Guardian Signature if request is by/for a child or youth:_____

SECTION 3 **AUTHORIZED COUNTY USE ONLY**

Clinical Data

DSM-IV

Axis I_____

Axis II_____

Axis III_____

Axis IV_____

_____

Medications: Specify dosage and frequency:_____

REVIEWED BY:_____

DATE:_____

RECOMMENDATION:_____

_____

_____

_____

Referral To:_____Notified:_____Date:_____

Appointment:_____Beneficiary/Client Contacted:_____

RFCOP2
LA

Name _____**MIS#**_____

Facility/Practitioner:_____

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